FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039842

Facility Name: CLAREMONT REHAB & LIVING CENTER

Address: 150 NORTH WEILAND (Number) BUFFALO GROVE (City) 60089 (Zip Code)

County: LAKE

Telephone Number: (847) 465-0200 **Fax #** (847) 465-0400

IDPA ID Number: 36-3976986-60089-0

Date of Initial License for Current Owners: 11/22/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRUCE LEDERMAN
(Title) VICE PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	200	Skilled (SNF)	200	73,200	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	200	TOTALS	200	73,200	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			13,481	13,481	8
9	SNF/PED					9
10	ICF	27,023	15,265		42,288	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,023	15,265	13,481	55,769	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 76.19%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/22/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/22/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 98 and days of care provided 11,478

Medicare Intermediary ADMINISTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTEI # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	352,622	30,532	26,326	409,480		409,480		409,480			1
2	Food Purchase		299,903		299,903		299,903	(19,586)	280,317			2
3	Housekeeping	221,814	41,034		262,848		262,848		262,848			3
4	Laundry	38,435	5,234	2,827	46,496		46,496		46,496			4
5	Heat and Other Utilities			202,130	202,130		202,130		202,130			5
6	Maintenance	81,676	7,511	108,084	197,271		197,271	(4,504)	192,767			6
7	Other (specify):*			25,215	25,215		25,215		25,215			7
8	**TOTAL General Services**	694,547	384,214	364,582	1,443,343		1,443,343	(24,090)	1,419,253			8
	B. Health Care and Programs											
9	Medical Director			42,500	42,500		42,500		42,500			9
10	Nursing and Medical Records	3,540,349	279,807	74,259	3,894,415		3,894,415		3,894,415			10
10a	Therapy	575,506	6,213	32,099	613,818		613,818		613,818			10a
11	Activities	118,328	10,004	25,346	153,678		153,678		153,678			11
12	Social Services	57,457		7,246	64,703		64,703		64,703			12
13	Nurse Aide Training											13
14	Program Transportation			3,594	3,594		3,594		3,594			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,291,640	296,024	185,044	4,772,708		4,772,708		4,772,708			16
	C. General Administration											
17	Administrative	253,862			253,862		253,862		253,862			17
18	Directors Fees											18
19	Professional Services			176,482	176,482		176,482	27,311	203,793			19
20	Dues, Fees, Subscriptions & Promotions			62,800	62,800		62,800	(28,192)	34,608			20
21	Clerical & General Office Expenses	319,672	22,567	51,857	394,096		394,096	(104,614)	289,482			21
22	Employee Benefits & Payroll Taxes			648,362	648,362		648,362		648,362			22
23	Inservice Training & Education			6,287	6,287		6,287		6,287			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			5,527	5,527		5,527		5,527			25
26	Insurance-Prop.Liab.Malpractice			172,180	172,180		172,180	18,529	190,709			26
27	Other (specify):*			142,467	142,467		142,467	(142,467)				27
28	**TOTAL General Administration**	573,534	22,567	1,265,962	1,862,063		1,862,063	(229,433)	1,632,630			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,559,721	702,805	1,815,588	8,078,114		8,078,114	(253,523)	7,824,591			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: CLAREMONT REHAB & LIVING CENTER #0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	15,053	
	REPAIRS & MAINTENANCE		2,394	
	OUTSIDE SERVICES		8,879	26,326
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		2,827	
			0	2,827
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		75,804	
	ELECTRICITY		96,858	
	WATER		25,597	
	CABLE TV - LOBBY		3,871	
			0	202,130
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		13,670	
	PAINTING & DECORATING		11,700	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		67,516	
	ELEVATOR MAINTENANCE & REPAIR		7,035	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		975	
	FIRE SERVICE		7,188	
			0	
			0	
			0	108,084
7	**OTHER**			
	SCAVENGER		24,840	
	SECURITY SERVICE		375	25,215
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	42,500	42,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	15,478	
	LABORATORY & XRAY EXPENSE		53,753	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,128	
	PHARMACY CONSULTANT	XVIII B 39-2	900	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	74,259
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	32,099	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	32,099
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	200	
	CLERGY		25,146	25,346
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	7,246	
			0	7,246
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER #0039842 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		3,594	3,594
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	0	0
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	28,003	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	148,479	
			0	176,482
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	21,877	
	EMPLOYEE WANT ADS	XIX F	6,332	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	20,596	
	LICENSES & PERMITS	XIX F	6,550	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	5,165	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	190	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	960	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,130	62,800
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		899	
	EQUIPMENT REPAIR & MAINTENANCE		800	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	41	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		805	
	TELEPHONE		33,056	
	MESSENGER SERVICE		0	
	COMPUTER MAINTENANCE		16,256	51,857

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	404,374	
	UNEMPLOYMENT COMPENSATION	XIX D	49,882	
	WORKERS COMPENSATION INSURANCI	XIX D	94,153	
	HOSPITALIZATION INSURANCE	XIX D	89,932	
	EMPLOYEE BENEFITS - OTHER	XIX D	6,681	
	EMPLOYEE PHYSICAL EXAMS	XIX D	3,340	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	648,362
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		6,287	6,287
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,527	5,527
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		172,180	172,180
27	**OTHER**			
	BAD DEBTS	VI 24	142,467	
				142,467

GRAND TOTAL COLUMN 3 OTHER 1,815,588

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER #0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			60,665	60,665		60,665	364,711	425,376			30
31	Amortization of Pre-Op. & Org.							14,039	14,039			31
32	Interest			32,174	32,174		32,174	1,051,371	1,083,545			32
33	Real Estate Taxes							215,770	215,770			33
34	Rent-Facility & Grounds			1,560,000	1,560,000		1,560,000	(1,560,000)				34
35	Rent-Equipment & Vehicles			43,173	43,173		43,173		43,173			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,696,012	1,696,012		1,696,012	85,891	1,781,903			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		503,635	108,267	611,902		611,902		611,902			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			109,800	109,800		109,800		109,800			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		503,635	218,067	721,702		721,702		721,702			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,559,721	1,206,440	3,729,667	10,495,828		10,495,828	(167,632)	10,328,196			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(18,428)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	139,423	30		9
10	Interest and Other Investment Income	(3,725)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,158)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(190)	20		17
18	Fines and Penalties	(41)	21		18
19	Entertainment		20		19
20	Contributions	(960)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers	(981)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(142,467)	27		24
25	Fund Raising, Advertising and Promotional	(21,877)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(5,165)	20		28
29	Other-Attach Schedule	(109,077)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (164,646)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(2,986)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (2,986)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (167,632)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CLAREMONT REHAB & LIVING CENTER

ID# 0039842

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ -4504	6	1
2	MARKETING SALARY	(55,303)	21	2
3	NON WORKING RELATED PARTY SALARY	(49,270)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
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31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(109,077)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(19,586)	0	0	0	0	0	0	0	0	0	0	(19,586)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,504)	0	0	0	0	0	0	0	0	0	0	(4,504)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(24,090)	0	0	0	0	0	0	0	0	0	0	(24,090)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(981)	28,292	0	0	0	0	0	0	0	0	0	27,311	19
20	Fees, Subscriptions & Promotions	(28,192)	0	0	0	0	0	0	0	0	0	0	(28,192)	20
21	Clerical & General Office Expenses	(104,614)	0	0	0	0	0	0	0	0	0	0	(104,614)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	18,529	0	0	0	0	0	0	0	0	0	18,529	26
27	Other (specify):*	(142,467)	0	0	0	0	0	0	0	0	0	0	(142,467)	27
28	**TOTAL General Administration**	(276,254)	46,821	0	0	0	0	0	0	0	0	0	(229,433)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(300,344)	46,821	0	0	0	0	0	0	0	0	0	(253,523)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	139,423	225,288	0	0	0	0	0	0	0	0	0	364,711	30
31	Amortization of Pre-Op. & Org.	0	14,039	0	0	0	0	0	0	0	0	0	14,039	31
32	Interest	(3,725)	1,055,096	0	0	0	0	0	0	0	0	0	1,051,371	32
33	Real Estate Taxes	0	215,770	0	0	0	0	0	0	0	0	0	215,770	33
34	Rent-Facility & Grounds	0	(1,560,000)	0	0	0	0	0	0	0	0	0	(1,560,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	135,698	(49,807)	0	0	0	0	0	0	0	0	0	85,891	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(164,646)	(2,986)	0	0	0	0	0	0	0	0	0	(167,632)	45

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
BRUCE LEDERMAN	47.5			WINDSOR MGMT		MANAGEMENT
HAROLD LEDERMAN	47.5			FREEDOM HOME	BUFFALO GROVE	HOME CARE
ANDREA WEITZBERG	5.0			CARE		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 1,560,000	WINDSOR HEALTHCARE MANAGEMENT ASSOC		$	$ (1,560,000)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V	19	PROFESSIONAL FEES		WINDSOR HEALTHCARE MANAGEMENT ASSOC		28,292	28,292	6
7	V	30	DEPRECIATION		" " " "		225,288	225,288	7
8	V	31	AMORTIZATION		" " " "		14,039	14,039	8
9	V	32	INTEREST		" " " "		1,055,096	1,055,096	9
10	V	33	REAL ESTATE TAX EXPENSE		" " " "		215,770	215,770	10
11	V	26	HAZARD INSURANCE		" " " "		18,529	18,529	11
12	V								12
13	V								13
14	Total			$ 1,560,000			$ 1,557,014	$ * (2,986)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTE # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRUCE LEDERMAN	ADMINISTRATOR	ADMIN	47.50				SALARY	$ 158,001	17-1	1
2	ALAN BURACK		MARKETING					SALARY	55,303	21-1	2
3	S BURACK							SALARY	49,270	21-1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 262,574		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTEI # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	PRUDENTIAL ASSET RESOURSES	X		MORTGAGE	$99,319.00		$	$ 14,570,414	06/01/2034	7.2500	$ 1,055,096	1
2												2
3												3
4												4
5												5
	Working Capital											
6	LASALLE BANK		X	WORKING CAPITAL	INTEREST			521,313		PRIME+	24,328	6
7	LASALLE BANK		X	WORKING CAPITAL	$13,889.00			83,333			7,846	7
8												8
9	TOTAL Facility Related				$113,208.00		$	$ 15,175,060			$ 1,087,270	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$ 15,175,060			$ 1,087,270	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 215,770	2
3. Under or (over) accrual (line 2 minus line 1).		$ 215,770	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 215,770	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	165,681	8
	2000	172,103	9
	2001	182,528	10
	2002	207,185	11
	2003	215,770	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME CLAREMONT REHAB & LIVING CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0039842

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-33-404-140	NURSING HOME	$ 215,769.96	$ 215,769.96
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 215,769.96	$ 215,769.96

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 86,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1994	$ 551,078	1
2					2
3	TOTALS			$ 551,078	3

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	200		1994	1994	$ 8,490,995	$ 212,670	39	$ 217,718	$ 5,048	$ 2,276,836	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	EXTERIOR SIGN			1995	3,113	80	39	80		710	9
10	NURSING STATION			1995	2,634	68	39	68		592	10
11	CONDENSOR			1995	11,363	291	39	291		2,437	11
12	SODING, PLANTING			1995	1,350	35	39	35		287	12
13	REPLACE SWITCHES			1995	2,732	70	39	70		569	13
14	INSTALLED OUTLETS			1995	1,651	42	39	42		338	14
15	INSTALLED CIRCUITS			1996	2,360	61	39	61		440	15
16	SHRUBS			1996	5,480	365	15	365		2,742	16
17	CEILING FIRE DAMPERS			1997	11,500	295	39	295		1,905	17
18	LEAD SHOWER PANS			1997	6,875	176	39	176		1,078	18
19	HEATER REPAIR			1997	20,316	521	39	521		3,191	19
20	TILE			1997	4,890	125	39	125		755	20
21	CERAMIC TILE			1998	7,335	188	39	188		1,121	21
22	CARPETING			1998	25,777	661	39	661		3,774	22
23	WALL REPAIR/PAINT			1998	53,734	1,378	39	1,378		7,154	23
24	EXIT SIGNS			1998	1,860	48	39	48		250	24
25	REPLACE SIDEWALK, ASPHALT SEALING			1998	8,147	543	15	543		2,986	25
26	LANDSCAPE			1998	22,400	1,493	15	1,493		8,214	26
27	GAZEBO, PLAYGROUND EQUIPMENT			1998	32,800	2,187	15	2,187		12,030	27
28	ELEVATOR REPAIRS			1999	43,763	1,122	39	1,122		4,816	28
29	SIDEWALK			1999	4,900	327	15	327		1,471	29
30	LIGHTING/SENSOR/OUTLETS			2000	45,308	1,648	27.5	1,648		6,522	30
31	ELEVATOR REPAIRS			2000	62,821	2,284	27.5	2,284		7,504	31
32	SEWER REPAIR/SHOWER DRAIN REPAIR			2001	4,100	149	27.5	149		585	32
33	HVAC/UNIT REPAIR			2001	20,061	729	27.5	729		2,358	33
34	HOT WATER TANK			2001	36,873	1,341	27.5	1,341		4,818	34
35	KIDNEY DIALYSIS ROOM			2001	59,646	2,169	27.5	2,169		7,693	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DINING ROOM FLOOR	2002	$ 11,024	$ 1,482	20	$ 551	$ (931)	$ 1,653	37
38	PLUMBING WORK - LAUNDRY ROOM	2002	39,507	1,437	27.5	1,437		4,311	38
39	ELEVATOR FLOOR	2002	1,000	36	27.5	36		108	39
40	DIALYSIS BOOSTER PUMPS	2002	5,132	187	27.5	187		561	40
41	HEATING & A/C REPAIR	2002	1,300	47	27.5	47		146	41
42	PUMP PIT & DUCT REPAIR	2002	18,750	682	27.5	682		2,046	42
43	CONCRETE WATERPROOFING	2002	8,920	324	27.5	324		972	43
44	PLUMBING WORK	2003	58,659	2,133	27.5	2,133		3,111	44
45	FLOOR REPAIR	2003	1,000	36	27.5	36		53	45
46	REPAIR WALL AND PAINT	2003	16,680	607	27.5	607		885	46
47	HEATING & A/C REPAIR	2003	4,765	173	27.5	173		252	47
48	FIRE ALARM SYS REPAIRS	2003	3,895	142	27.5	142		207	48
49	FIRE DAMPERS	2004	2,298	38	27.5	38		38	49
50	WALLCOVERING & CARPET	2004	8,702	145	27.5	145		145	50
51	ELECTRICAL HEATER	2004	3,040	51	27.5	51		51	51
52	WALL MOUNT DIGITAL ROOM TEMP CONTROL	2004	1,500	25	27.5	25		25	52
53	DRAWER ASSY FOR UPGRADE OF BOILERS I&II	2004	7,277	121	27.5	121		121	53
54	BOILER/HOT WATER LINES/ACTUATORS	2004	12,690	212	27.5	212		212	54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 9,200,923	$ 238,944		$ 243,061	$ 4,117	$ 2,378,073	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 524,657	$ 26,278	$ 50,333	$ 24,055	8-15 YRS	$ 313,456	71
72	Current Year Purchases	13,522	8,113	676	(7,437)	10 YRS	676	72
73	Fully Depreciated Assets	35,328					35,328	73
74	RELATED PARTY	1,313,061	12,618	131,306	118,688	10 YRS	1,300,565	74
75	TOTALS	$ 1,886,568	$ 47,009	$ 182,315	$ 135,306		$ 1,650,025	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		FORD VAN	1998	$ 16,033	$	$	$	5	$ 16,033	76
77										77
78										78
79										79
80	TOTALS			$ 16,033	$	$	$		$ 16,033	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 11,654,602	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 285,953	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 425,376	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 139,423	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 4,044,131	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 27,593 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	PATIENTS	99 14 PASSNGR BUS	$ 899.00	$ 12,148	17
18	ADMINISTRATOR	04 HONDA ACCORD	384.30	4,252	18
19		AUDI		4,035	19
20			FRINGE BENEFITS	(4,855)	20
21	TOTAL		$ #######	$ 15,580	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 24,799	$		$ 24,799	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			4,797			4,797	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			2,991			2,991	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				503,635		503,635	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, RENTAL, OTHER SERVICES Other (specify):	39-3				75,680			75,680	13
14	TOTAL			$		$ 108,267	$ 503,635		$ 611,902	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 657,837	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 120,000)	3,208,813		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	179,274		6
7	Other Prepaid Expenses	59,214		7
8	Accounts Receivable (owners or related parties)	694,188		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,799,326	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	709,928		15
16	Equipment, at Historical Cost	589,540		16
17	Accumulated Depreciation (book methods)	(670,385)		17
18	Deferred Charges	6,625		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 635,708	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,435,034	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,994,297	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	521,313		29
30	Accrued Salaries Payable	309,204		30
31	Accrued Taxes Payable (excluding real estate taxes)	32,669		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,418		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,859,901	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	317,929		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 317,929	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,177,830	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,257,204	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,435,034	$	48

*(See instructions.)

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,319,596	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,319,596	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(62,392)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (62,392)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,257,204	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,088,490	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,088,490	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	321,332	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 321,332	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	7,627	12
13	Barber and Beauty Care	20	13
14	Non-Patient Meals	10,801	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 18,448	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,725	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,725	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**VENDING COMMISSIONS - NET**	578	28
28a	**PATIENT TRANSPORTATION**	863	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,441	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,433,436	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,443,343	31
32	Health Care	4,772,708	32
33	General Administration	1,862,063	33
	B. Capital Expense		
34	Ownership	1,696,012	34
	C. Ancillary Expense		
35	Special Cost Centers	611,902	35
36	Provider Participation Fee	109,800	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,495,828	40
41	**Income before Income Taxes (line 30 minus line 40)****	(62,392)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (62,392)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,264	$ 72,395	$ 31.98	1
2	Assistant Director of Nursing					2
3	Registered Nurses	44,434	46,894	1,364,923	29.11	3
4	Licensed Practical Nurses	8,925	9,329	219,488	23.53	4
5	Nurse Aides & Orderlies	113,028	121,637	1,385,259	11.39	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	14,629	16,365	425,920	26.03	7
8	Rehab/Therapy Aides	10,203	11,516	149,586	12.99	8
9	Activity Director					9
10	Activity Assistants	11,204	12,007	118,328	9.85	10
11	Social Service Workers	4,106	4,486	57,457	12.81	11
12	Dietician					12
13	Food Service Supervisor	3,856	4,608	86,911	18.86	13
14	Head Cook					14
15	Cook Helpers/Assistants	30,397	32,006	265,711	8.30	15
16	Dishwashers					16
17	Maintenance Workers	5,815	6,135	81,676	13.31	17
18	Housekeepers	25,763	27,454	221,814	8.08	18
19	Laundry	4,396	4,861	38,435	7.91	19
20	Administrator	4,160	4,496	253,862	56.46	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	16,594	18,245	319,672	17.52	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,939	4,403	59,179	13.44	31
32	Other Health C: See Sch Attached	19,825	20,930	439,105	20.98	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	323,194	347,636	$ 5,559,721 *	$ 15.99	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 15,053	1-3	35
36	Medical Director	O	42,500	9-3	36
37	Medical Records Consultant	N	4,128	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	900	10-3	39
40	Physical Therapy Consultant	L	32,099	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	200	11-3	44
45	Social Service Consultant	E	7,246	12-3	45
46	Other(specify) CLERGY	S	25,146	11-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 127,272		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	442	$ 15,478	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)	442	$ 15,478		53

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRUCE LEDERMAN	ADMIN		$ 158,001
LARRY PUTZ	ADMIN		95,861
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 253,862

B. Administrative - Other

Description	Amount
	$ 0
TOTAL (agree to Schedule V, line 17, col. 3)	$ 0
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		176,482
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 176,482

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 94,153
Unemployment Compensation Insurance		49,882
FICA Taxes		404,374
Employee Health Insurance		89,932
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		6,681
EMPLOYEE PHYSICAL EXAMS		3,340
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,250
Advertising: Employee Recruitment	6,332
Health Care Worker Background Check	1,130
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	27,042
TRUST/FRANCHISE/CONTRIB/ETC	1,150
LICENSES & PERMITS	5,300
DUES & SUBSCRIPTIONS	20,596
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(1,150)
Less: Public Relations Expense	(0)
Non-allowable advertising	(21,877)
Yellow page advertising	(5,165)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,608

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 0

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	2001	$ 7,721	3	$ 1,287	$ 2,574	$ 2,574	$ 1,286	$	$	$	$	$
2	PAINTING/DECORATIN	2003	11,880	3			1,980	3,960	3,960	1,980			
3	PAINTING/DECORATIN	2004	11,700	3				1,950	3,900	3,900	1,950		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 31,301		$ 1,287	$ 2,574	$ 4,554	$ 7,196	$ 7,860	$ 5,880	$ 1,950	$	$

Facility Name & ID Number CLAREMONT REHAB & LIVING CENTER # 0039842 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA $10,800**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **73,347** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **109,800**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **19,006**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees